THE MISSISSIPPI DOCTOR

VOL. 9. BOONEVILLE, MISSISSIPPI, APRIL, 1932. NO. 11

Ode to the Doctor

"Who works from morn till set of sun,
The whole day long is on the run,
And yet whose work is never done?
The Doctor.

"Who's roused up in the dead of night
By some one in a dreadful fright
Who's sure she's going to die tonight?
The Doctor.

"Who when the days are shocking hot
Can seek no cool sequestered spot
Because he must be on the trot?
The Doctor.

"Who when the mercury is low,
Long weary miles must often go,
Through cutting winds and blinding snow?
The Doctor.

"Who has to hear the countless ills
And deal out multitudes of pills
To those who never pay their bills?
The Doctor.

"Who must not show that it's a bore
To hear each family history o'er
Five generations back and more?
The Doctor.

"Who should be placed among the saints
Whom history with us acquaints
For patient listening to complaints?
The Doctor."

PRACTICAL APPLIANCES FOR THE BUSY PHYSICIAN

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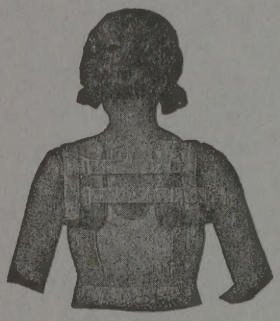

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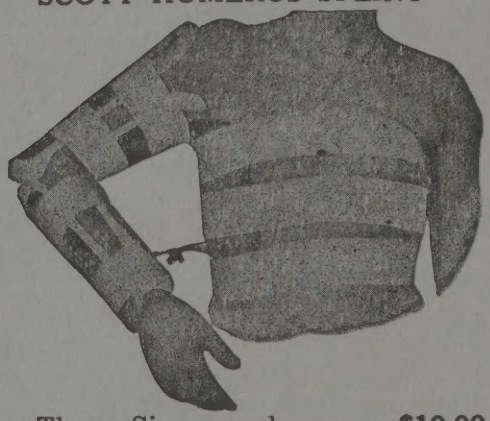

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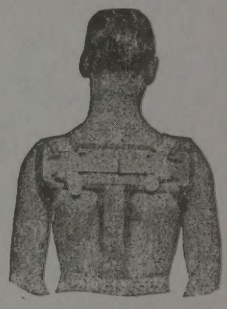

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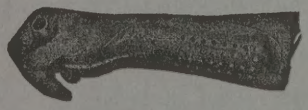

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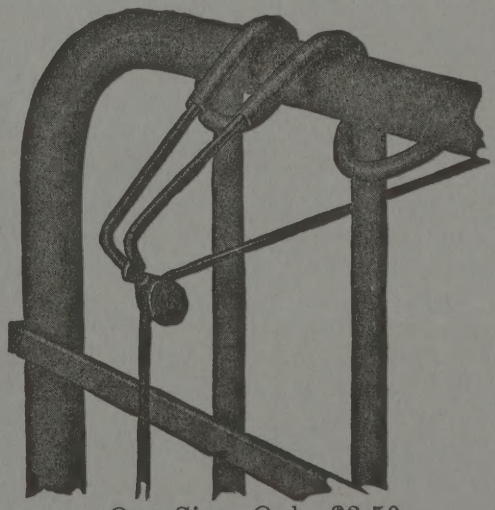

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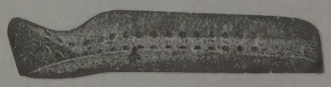

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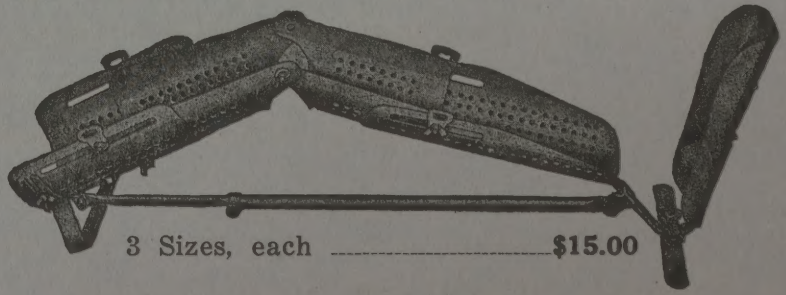

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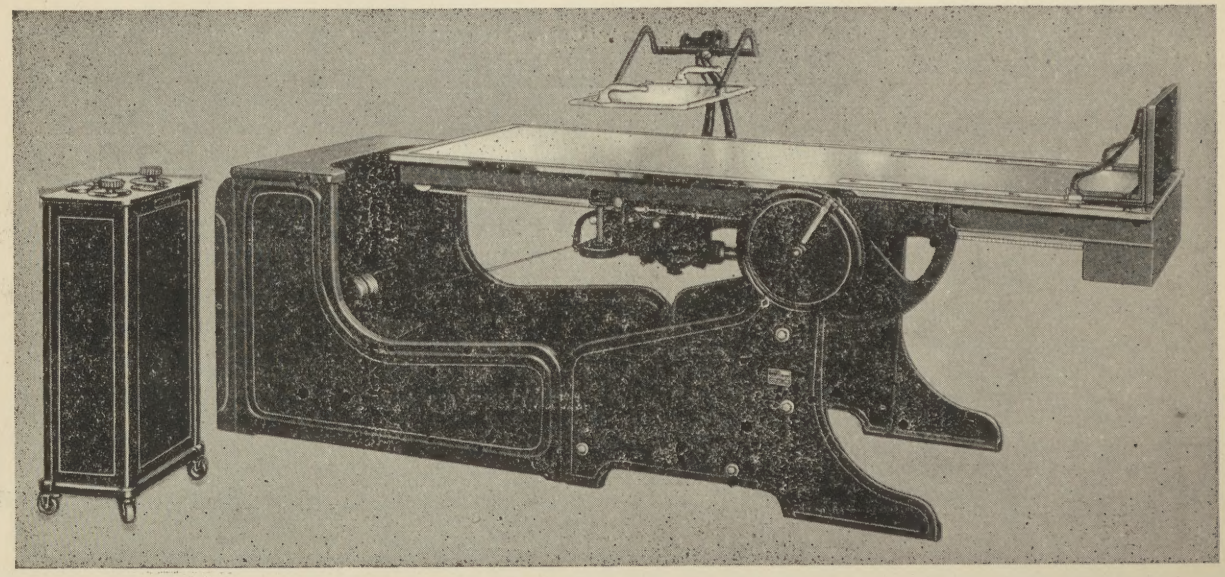

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THE MISSISSIPPI DOCTOR

OFFICIAL ORGAN OF THE NORTHEAST MISSISSIPPI 13-COUNTY MEDICAL SOCIETY
—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1879.

Our two year medical department has been threatened by a legislative committee. We want to admonish them to go slow and to be more careful in their statements. We trust that they will read Dr. Culley's address in full and get the facts more clearly before them. We can not afford to give up this school. It has rendered too much service. It has much more to do. Our man power is our greatest wealth. Its education and the conservation of its health is our most important duty. We need to give our own young men a medical education and we need to have their services. Many young men a medical education and we need to have their services. Many young men who have the medical soul throbbing within their bosom can go to Ole Miss for two years who are unable to go out of the state for the four years. It is not too expensive Mr. Legislative Committee. Don't say this again. It is an investment that you can not afford to not make. When you get in debt you must invest and make profit to enable you to get out. It is true that Mississippi is now convalescing from Typhoid financially speaking, but if you buy an educational suit to fit at this time, if the state lives, and live she will, then in a few months or years at most, you will have to discard a good suit and buy another one. You will have a waste. We can not give up our medical school. We can not, we must not, we will not. Let every member of the profession come to its aid at this time.

The British Medical Journal, London, contains the announcement that at a meeting of the Council of the Royal College of Surgeons of England, Lord Moynihan, President, in the chair, The Right Hon. Lord Dawson of Penn, P.C., G.C., V.O., K.C.B., K. C. M. G., Physician to His Majesty the King, and President of the Royal College of Physicians of London, and Sir Henry Wellcome, LL.D., F.S.A., founder of The Wellcome Research Institution, were elected Honorary Fellows of the Royal College of Surgeons.

The Royal College of Surgeons of England is one of the most exclusive scientific bodies in England, and the bestowal of this honor on Sir Henry Wellcome is very exceptional in that aside from members of the Royal Family, Sir Henry is the second person not holding a medical degree upon whom this rare distinction has been conferred, the first and only other recipient being the famous Field Marshall, Lord Roberts of Kandahar.

Sir Henry Wellcome is of American birth and is well known for his world-wide scientific work and extensive pioneer researches in connection with tropical diseases, including the founding of The Wellcome Tropical Research Laboratories at Khartoum on the Upper Nile Regions of the Sudan, Africa. He is also a Director of the Gorgas Memorial Institute, Washington, D. C., with its Tropical Research Laboratories at Panama.

Our state meeting was moved up to April to get out of the way of the A. M. A. It was held in Jackson, our state capital, at the new Robert E. Lee Hotel, which hotel did itself proud in entertainment. Dr. J. C. Culley was president. His address was on medical education. It was able and instructive. He made a strong plea for the medical department at Ole Miss. Dr. W. S. Leathers, former dean of Medicine at Ole Miss and Secretary of the Board of Health of Mississippi, and now Dean of the Medical Department of Vanderbilt University was the orator of the occasion. He spoke on the relation of public health and general practice and the future outlook of both. It was a masterful oration. Every physician in the state, in fact every citizen should have heard both addresses. They should yet be published in every paper in the state. Mississippi can ill afford to lose the medical department at Ole Miss. It is reaching many worthy young men who are permeated by the medical spirit and who could not go out of the state for the full four year course. It is not costing the state so much as some legislative committees would have us believe. Our two year course stands at the top of the list for the ten two year schools in the U. S. A. Legitimate public health is our great barrier to state medicine. Dr. Leathers paid high tribute to our public health department. We still claim Dr. Leathers. We are just lending him to Vanderbilt.

The different sections presented fine programs. Dr. Edley Jones was alive on the job for the eye, ear, nose and throat department, Dr. Smith of Vicksburg, one of the outstanding public health officers of Mississippi and the South did himself honor for his department; Dr. Rembert put up a strong bunch of essayists, the surgical section came up strong, and Dr. Adkins deserves plenty of honor for his program on the radiological section. Dr. W. W. Robinson's discourse on chronic appendicitis with his slides was in keeping with the masterful student he is. Dr. Martin of Dallas on the Cancer Problem was worth crossing the continent to hear. Dr. Rembert's program was strong throughout. Dr. Brown of Little Rock suggested a most valuable line of thought peculiar to practice at this time along the suicidal tendencies of the times. We did not hear many of the papers of the eye, ear, nose and throat section and public health, but we heard enough to make us know that they were up to a high standard. The local men in all departments had fine papers as well as the out-of-state essayists. On the surgical section Drs. Sanders, Dabney and Haggard brought forth much favorable comment. Dr. Sanders is one of the thorough students of the South, Dr. Dabney is a native of Mississippi, one to whom we love to do honor and in whom we feel a pride, an able gynecologist and editor of the Southern Medical Journal, while Dr. Haggard is a former president of the A. M. A., a surgeon of national reputation, and a ranking orator of the "world."

Six hundred and sixty-six registered at the state meeting. Taking into consideration the "times" this was a wonderful showing. It is evidence of the fine work President Culley did as president. Nothing counts like the spoken word impressively said. Dr. Culley traveled the state, carried his ideas and conveyed those of one section to another. His work as president was monumental.

Dr. Lowrey Rush of Meridian is a new member of the Council. He is a thorough student, full of medical optimism, and he possesses a personality charged with inate culture and refinement. He will do honor to the honor conferred upon him.

Dr. Dicks of Natchez is the president elect of the State Medical Association. He has served as secretary of the council for a number of years. For many years he has rendered valuable service to organized medicine in Mississippi. He is one of the most systematic thinkers and workers in the medical profession of Mississippi. In physique he is perhaps our most distinguished in appearance. He has plenty of personality. He practices medicine with ease because of the love he has for it. We predict for him an able administration.

Dr. Joe Green is another new member of the council. Dr. Joe has the mother wit. He is an outstanding medical philosopher. He will make a fine member of the council.

The Mississippi State Hospital Association had a most successful meeting at the Edwards Hotel on Monday April 11th. Dr. Leon S. Pippincott did honor to the association as its president. He is a systematic worker and does not let up until victory is accomplished. Will Ross of Milwaukee was the special speaker of the evening. Gov. Conner was unable to attend. Dr. J. Gould Gardiner of Columbia was elected president of the association. This honor was well and worthily bestowed. Dr. Gardiner is one of the sane, sensible and sound surgeons of the state. He can be depended upon for safe leadership. Much good will result from these hospital meetings. We must put more business into hospital management. We must learn what constitutes the essentials and must leave off a lot of the expensive show. With all due respect to everybody, we have not had very much real sensible business applied in our hospitals, generally speaking. Hospitals can yet be operated for less money and still furnish more efficiency and can make some profit on the investment. The hospital organization of our state has before it a great outlook for service.

The next meeting of our society will be held in Amory. It will be good to be there.

The American Medical Association will hold its annual session in New Orleans, May 9th to 13th. Mississippi should be well represented. The A. M. A. is a great organization. New Orleans is a wonderful city in which to visit. It is the oldest and the newest, the most beautiful and the ugliest, the most cosmopolitan and the most provincial, the most learned and the most ignorant, the most progressive and the most backward of any you will visit. But it is a friendly city. It is a city you will love. It grows on you. It is the home of Tulane, the greatest all-round under-graduate medical school in America. Tulane is making rapid strides under Dean Bass, a native Mississippian, who makes our hearts swell with pride. It is the home of Dr. Rudolph Matas, our most versatile professional mind, the man with a medical soul and a missionary heart. New Orleans is the home of one of the book stores of Dr. J. A. Majors, a native son of Booneville, who is always bubbling over with optimism and good cheer, one of the cleverest of the clever. Go to the A. M. A. if at all possible.

Dr. James A. Acker Jr., of Aberdeen, our efficient secretary, is now president of the Mississippi State Medical Association. He will do honor to himself, to our society and to the state association. He is a systematic worker. He will be actively on the job. We are proud to have Dr. Jim president of the state association.

You will read with interest and profit the paper of Dr. Norwood. In some quarters too much importance may have been attached to laboratory tests, but as a rule we do not have enough of it by a lot. This is an age that is calling for efficient application of the already known and tried medical truths. It is not so much that the doctor does not know that he lets important things slip by him on diagnosis, but it because he does not do, does not make the careful and systematic examination on every patient that he should. A blood smear, urine analysis, Wassermann test, and feces examination should be included in the routine in the first examination. It is true that we need to renew our interest in clinical symptoms, they are the sheet anchors, but the laboratory tests come hard by their side. Get the laboratory habit. Do or have it done. Heed the admonition of Dr. Norword.

Diagnosis and Treatment of Perforated Gastric and Duodenal Ulcer by Dr. R. D. Kirk with the discussions will give you the latest and the best on the subject. Dr. Kirk has had an unusually large number of these cases. Personally we are strong for the "Cold Patch" plan having had four cases, two gastric and two duodenal without the loss of one. We also believe in drainage in the average case.

Dr. Philpot, Secretary of the Hospital Committee, made a report to the association at its recent meeting. The report was accepted and the committee was continued. The bill being sponsored by the committee is to proportion the funds over the state on a per capita basis. This is fair and just. It will mean much to the development of more efficient medicine in the small town. Modern medicine is even now on its march to the country and small town. The town of two to twenty thousand population will be the meeting place of the profession and the rank and file of our population. The development of medical centers in the small town is the answer to the high cost of medical care. The equal distribution of funds by the state for the actual charity will aid this move very greatly. You should stay behind the hospital committee until this job is finished. See or write your representative.

You will notice an announcement of the meeting of the Proctological Society which is to convene in Memphis. Many general practitioners would do well to attend this society. A rectal examination needs to be made a hundred times more often than it is. The general practitioner needs to have a general knowledge of rectal diseases and he needs to know when they should be referred to the specialist.

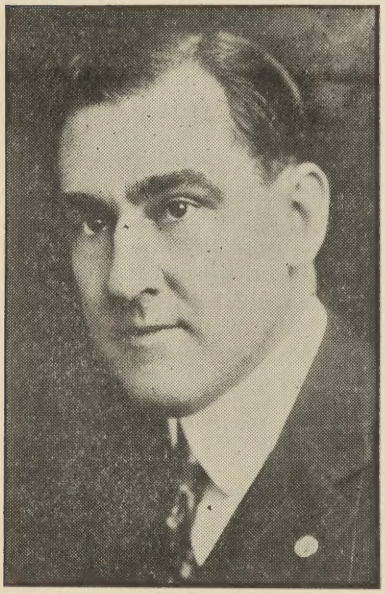
For the next thirty days we are offering The Mississippi Doctor for one year for one dollar. The Mississippi Doctor has a mission. It has been the champion of the small hospital. It is the leader of modern medicine to the country. It is trying to raise the efficiency of the general practitioner of medicine and surgery. It is the journal of the rank and file of the profession. It stands for every good cause in which the entire profession is interested. We believe you will be pleased with the journal. Some of you have had it without cost. You can be a help to the journal. The journal will help you. Will you not help us to double the subscription list. Send us your one dollar for your subscription. Ask your friends to subscribe. Help your self to solve your medical problems through a Mississippi Journal.

People continue to get sick and die of common every day diseases. The average practitioner should be able to do as much for eighty five per cent of those as the specialist.

We have plenty of physicians in practice to take care of the people of the United States. What we need is to sell them to the small town and rural community and de-centralize the profession.

The physician that is always ascribing ulterior motives of "politics" to his fellow practitioner will usually bear close watching.

A. F. Cooper, M.D.



The above is a good likeness of Dr. Arthur F. Cooper, Secretary of the Mid-South Post Graduate Medical Assembly, formerly the Tri-States. This association meets at the same place each year, the Peabody Hotel, all the lectures are in one assembly room. The program tries to cover major subjects in medicine and surgery. The essayists are the best that can be found in the United States. Their symposiums are the last word on the subject. It is doubtful if you can find another medical assembly that offers so much in such a short time. It epitomizes the latest and the best in profession in a four day course. It gives the essentials to the specialist and at the same time enlightens the general practitioner and teaches him to know when he should refer his patient. It has a broadening effect both on the specialist and the practitioner, helps them to corrolate their work.

Cordiality and good fellowship reigns supreme at this assembly. Southern culture and hospitality still holds strong in Memphis, Tennessee, on the banks of the Father of Waters. It is a city of satisfied inhabitants, and a city that you like to visit again and again.

The Peabody Hotel, the home of the Mid-South Assembly is not to be surpassed in America when it comes to accomodations that please the guests. It is especially suited to the conveniences of conventions.

It does seem that people are born to a purpose, that they are predestined and foreordained to a special work. At any rate you could not make out your order and get a secretary that is so suited in every detail of manner and efficiency as is Dr. Cooper. "The work we love to do physics pain." He is the embodiment of ease, pleasure and efficiency as secretary of the Mid-South Post-Graduate Medical Assembly. He knows how to select the best men in the field of medicine, he inspires them to their best efforts and he does not over look one little thing that adds to the profit and the pleasure of the attendant of this association. When the unseen hand was assorting the human parts for medical secretaries the choice pieces were laid aside for Dr. A. F. Cooper and the Mid-South Association. He is rendering a fine service to the profession of this territory along with the splendid program committee. The profession appreciates his services and those of the committee. The Mid-South Post Graduate Medical Assembly has yet a still bigger field of service. We congratulate Dr. Cooper for his part in this public service and we sincerely appreciate his efforts and accomplishments.

Book Review

"Modern General Anesthesia", by Dr. James G. Poe, and published by the F. A. Davis Co., Philadelphia, Pa., is the most replete and comprehensive book on anesthesias that has fallen into our hands of late. This is essentially a text-book so clearly and thoroughly defining the signs and conditions of each stage of operative and toxic degrees of ether anesthesia, nitrous oxide, ethylene and chloroform, that a beginner might distinguish them. The task of the anesthetist magnified by a detailed discussion, step by step, of the administration of these anesthesias, with major attention being given respiration and the problems incidental to it in the anesthetic state. A further chapter is given to the choice of the anesthetic for patients of given diseases and where special physiological and pathological conditions exist, with methods for administration, and the pre- and postanesthetic care. Non-volatile and local anesthesias likewise receive illuminative but brief attention.

Every practicing physician needs one of these books for a source of accurate reference for himself and his assistants. Price: $2.50.

Program

AMERICAN PROCTOLOGIC SOCIETY

Memphis

Friday and Saturday, May 6 and 7, 1932

Headquarters: The Hotel Peabody.

Arrangements: Dr. John L. Jelks, Memphis. Dr. Victor K. Allen, Tulsa.

TENTATIVE SUMMARY OF EVENTS

Friday, May 6th—

8:00 A.M.—Registration—Hotel Peabody.

9:00 A.M.—First Session—Hotel Peabody.

1:30 P.M.—Second Session—Hotel Peabody.

7:30 P.M.—Third Session—Hotel Peabody.

9:30 P.M.—Annual Executive Meeting (for Fellows only)—Hotel Peabody.

Saturday, May 7th—

8:00 A.M.—Operative Clinics—Memphis General Hospital—Dr. John L. Jelks, M.D., F.A.C.S., and Associates.

10:00 A.M.—Pathological Demonstrations—Pathological Institute, University of Tennessee, Dr. H. C. Scheisser, Director.

Proctozoology—Dr. John A. McIntosh, Pathological Lab., St. Josephs Hospital. Miss Helen Peck Bacteriologist, Baptist Hospital.

2:00 P.M.—Fourth session—Library, University of Tennessee.

7:00 P.M.—Annual Society Dinner—Hotel Peabody. (Registered Guests Invited.)

Sunday, May 8th—

Tour of Memphis and surroundings. Automobiles at Second St. entrance, Hotel Peabody.

THE SCIENTIFIC PROGRAM

will include the following presentations:

"Prophecy and Fulfillment"—Presidential Address Dr. W. O. Hermance, Philadelphia.

Addresses of Welcome—Dr. P. W. Toombs, President of Memphis and Shelby Co. Medical Society, Memphis. Dr. O. M. Hyman, Administrative Officer, University of Tennessee, Memphis.

"The Literature of 1931"—Cecil D. Gaston, M.D., F.A.C.S., Birmingham.

"Sarcoma and Melanoma of the Rectum"—Herbert I. Kallet, M.D., F.A.C.S., Detroit.

"Detached Tunnel Skin Grafts Into Stricture of the Rectum"—Raymond L. Murdoch, M.D., Oklahoma City.

"Colonic Mucorrhea"—Curtis C. Mechling, M.D., F.A.C.S., Pittsburg.

"The Mucin Treatment of Colitis"—Clement J. DeBere, M.D., F.A.C.S., Chicago.

"Malformations of the Anus"—Victor K. Allen, M.D., Tulsa.

"Histology and Embryology of the Ano-Rectal Line"—Hary E. Bacon, M.D., Philadelphia.

"Anal Anatomy and Anal Terminology"—James K. Anderson, M.D., Minneapolis.

"Recto-Urethral Fistula"—Charles E. Howard, M. D., F.A.C.S., Cincinnati.

THE SYMPOSIUM ON RECTAL CANCER

The program committee offers as the special feature of the Scientific Program for the 1932 meeting a comprehensive consideration of every phase of rectal malignancy; the symposium will be given on Friday afternoon.

The subject will be divided as follows:

"Anatomy and Etiology"—Charles E. Pope, M.D., Chicago.

"Diagnosis"—Louis A. Buie, M.D., F.A.C.S., Rochester, Minn.

"Preoperative Treatment and Palliative Colostomy"—Descum C. McKenney, M.D., F.A.C.S., Buffalo.

"One and Two Stage Perineal Procedures"—Walter A. Fansler, M.D., F.A.C.S., Minneapolis.

"One Stage Abdomnoperineal Procedure"—T. E. Jones, M.D., F.A.C.S., Cleveland.

"Two Stage Abdomnoperineal Procedures"—Dudley Smith, M.D., F.A.C.S., San Francisco.

"Operative Complications and After Care"—Louis J. Hirschman, M.D., F.A.C.S., Detroit.

Discussion of the Cancer Symposium will be led by:

John L. Jelks, M.D., F.A.C.S., Memphis.
Jay L. Clemons, M.D., Los Angeles.
Curtice Rosser, M.D., F.A.C.S., Dallas.
Jerome M. Lynch, M.D., F.A.C.S., New York City.

A Plea for More General Use of Laboratory Methods as an Aid in Diagnosis

BY DR. CARL W. NORWOOD
Corinth, Miss.

It is presumptous on my part to attempt to relate to you that the laboratory is essential to all engaged in the art of healing. That is not my purpose in coming before you on this subject; but the fact remains that most of us, who have not grown up with the use of the laboratory since our beginning the practice of medicine, do not depend upon it as we might.

There are so many instances where, if we were to apply the aid of the laboratory, it would save many patients who drift away to some cult or to someone else. There are cases which we visit for the first time, for example, the patient who has a chill with perhaps some other vague symptoms; the fact is ,we do not know what the diagnosis really is. As a result, we give the patient symptomatic treatment and along with it the grayhairs in our head multiply from day to day as we wonder if the patient will improve, knowing not from day to day what to expect. I suggest to you tnat the laboratory will save you much worry and not only save you these gray hairs and wrinkles, but you will really do justice by the patient and yourself in some case every day if you will carry a few slides in your case and when you visit a case where you have uncertainties, get a smear of a drop of blood on a slide and perhaps a specimen of urine from this patient.

And in case you are not equipped to make these examinations, send one of the family with these specimens to your nearest laboratory. Perhaps tell him that there will possibly be some charge for this but that it is necessary in the patient's behalf in the procedure of further treatment.

If you are not satisfied with some reports as to their significance in various findings it is easy to find out the significance of them in a relatively easy manner, for the laboratory will be able to give you their significance in must instances.

We have also that large percent of cases of so-called KIDNEY TROUBLE, "yes, awful kidney disease for so many years." "I have been given up", the patient will brag, naming a number who have treated him. "I have the incurable kind," they often say.

It is a bit enlightening to examine this patient's urine chemically and miscropically and be able to tell him all findings are normal. I mention this because we do find many of such cases.

And by elimination in adequate laboratory tests mentioned, we may then locate the true condition by further examination as being some

local trouble. But it is the greatest leap in the dark that I can imagine for anyone to attempt to treat any kidney disease, let it be present or imaginary, without the aid of laboratory findings.

Another case of chills comes in. And we say, "Oh yes, malaria," and fill in with quinine. The patient grows no better, day after day, but grows worse. We wish for light, darkness is in our pathway, and we toss on the pillow. In the first place, what should have we done? We should have got that patient's urine and a drop of blood on a slide and sent it to a good laboratory. It would have returned with a report. No malaria, high leucocyte, urine shows 2 to 4 plus, plus. Had we known this in the beginning we should have had our bearings and done justice by the patient.

Then we have cases of anemias. I mean those that are diagnosed from their appearance. We tonic, we tonic, we tonic. Let me say that there never was an anemia without a cause, and it is neither justice to ourselves nor to the patient if we have not got the laboratory reports, at least of the blood and urine, whereby, we find the cause and remove it, so that nature may then take hold and the patient's blood restore itself.

I realize that about as worthless a thing we can have is an undependable technician in laboratory. On the other hand, I cannot put too much stress on their importance to you, who have not availed yourself the aid of the laboratory daily. I believe if every practitioner would carry microscopic slides in his case in the place of purgative pills we would be able to save a much larger percent of the appendix cases at operation. Why we will continue to give dynamite doses of calomel, C. C. Pills, Castor Oil, and other such purgatives, in the face of all that has been said, is a mystery. When we visit a patient with a pain in the belly, let me suggest that we empty this patient's stomach in a simply way. Get him to vomit. I know of no better way than to give him several glasses of soda water then get him to stick his finger back of his tongue until he vomits, repeating this until it is free of food. Give this patient enema, heat his belly and, if necessary, an opiate to ease. Then get a drop of blood on that slide, and send a runner to a laboratory. If you have infection in the abdomen your test will indicate it. If not, your patient will possibly be well in a few days, then you can give him the purgative to hold your reputation and not for the good it will do.

We are realizing the increasing number of amoeba cases in this climate. We do not know if they are increasing or if more of us are using our laboratory facilities and are finding them more. A large percent of these, you know, give no symptoms directly, while others may be in a debilitated state from it.

I dare say there are half of the people who think we get malaria from the air, the water we drink, or from getting their feet damp, or from a poor watermelon. We can correct this by making a blood test and stating to them the facts as to how it is spread and cured. "Oh", they say, "I had to take purgative to free myself of malaria, and still the chills come on every other day." When we find Mr. Malaria plasmodium, we know that patient needs quinine for at least six weeks, then after that perhaps, until his blood shows that he is well.

The death rate in child birth is one of the few conditions which has not decreased. We know positively this could be cut down to an unknown quantity if we would get the urine of these patients at two-week intervals and apply appropriate treatment, as well as the routine blood-snear about twice during gestation. I do not mean this would take care of the need or necessity of these patients being cared for at hospitals, which is another important step necessary to save the life of many mothers, who are being daily lost, but I mean it is imperative to have this laboratory work done and the necessary treatment afforded to get this mother to time of delivery, so that she will have an equal chance of going through the delivery with a chance that is justly hers and to the child.

I am sure that both chemical and microscopic tests are necessary and indespensable if we are to do the job right. The reasons for this are too volumnious for me to go into at this time. But a large number feel as I do, personally, that laboratory work, to do it myself, is the brunt end of medicine, and to the average busy doctor, when he depends upon himself to do it, does that only which he has to. I do not believe any doctor will give it the time and detail that it deserves in his work, if he depends solely upon himself to do it, for no one minute of his existence is his. By the time he begins a test Johnnie comes running in with his toe mashed, or similar things. The doctor as a result says, "Oh, well, we will treat him for malaria, and let it go at that." That to my mind, is the reason for the prevalent neglect of this work. The majority of us are trained in laboratory work, but at this time we are grossly neglecting the essentials and hitting only the high points. I will relate two cases which have impressed me very much in recent months. One was a man who had been diagnosed for twelve years by his family physician for pulmonary tuberculosis. After blood tests, sputum and X-ray, it proved to be syphilitic lungs. A condition, of course, or a disease, which responds readily to appropriate treatment. During this time the wife of this patient had given birth to three still-born children. This mother's Wasserman was also three-plus.

If I felt a little rusty in my laboratory technique, I would advise getting a technician. If I did not do this, I would line up with some convenient laboratory or the technician of some other fellow, where it would be possible to get

your reports the same day they are made. Ten or twenty miles would be no obstacle to send these reports if we would let the family in each instance do the running, and of course, take the worry of the additional expense involved. Or I could write some good laboratory for instructions, as to the routine of urine, feces and blood and get specific instructions as to how to go about it, or, better still, take a day or two off and go to a laboratory and put my cards on the table and the technician will instruct me in the technique of taking smears and refresh my memory in the use of the microscope. This, I say, is not the best, but better than none. Also reference to text books will familiarize a doctor with the most important diseases requiring laboratory methods to make positive diagnosis.

Too often we make a patient suffer unnecessarily, because we make postive diagnoses from chemical observation only, when a few laboratory tests may reveal something entirely different and positive.

Pyelitis occurs very often in children, more so than one ordinarily thinks, particularly so in girls. And that irregular fever that is not readily, positively diagnosed should have a urine examination. It is surprising how often we will find pyelitis, for this condition is impossible to be diagnosed otherwise positively. Then after diagnosis for pyelitis and treatment, should the patient not improve, if not equipped to do Pyelogram and cystoscopy, send the patient to someone who can.

Again we see members of families who have been told that they have tuberculosis. We, of course, realize that we do not always find the Bug in the Sputum, even when the case is active. But if it is found you have more definite statements to make to the family and true facts in the case, that is of satisfaction to yourself, as to whether or not the bug is being thrown off. With this, along with your clinical evidence, and if possible, X-ray, you will do justice to your patient and yourself. There is too often diagnosis of tuberculosis without applying the laboratory tests and X-ray to verify it to aid in such decision. It is up to the medical profession largely to educate and overcome that prevalent laymen's idea of every case having tuberculosis that coughs or expectorates. It means too much to the patient's welfare, to society and all concerned, not to have proof in each instance where possible in making a diagnosis.

The total merit and benefit of accurate laboratory methods to both patient and doctor are volumnious to take up at this time in detail. The summary of my message and the point I wish to make is, that all too often many of us are neglecting the use of the laboratory as we should in our daily work. We are eager to read the daily paper. I see no reason why we should not be just as eager to get daily and read the laboratory reports of the cases that we have observed each day. Even if we get these the day following. And by doing this as part of our daily work several valuable benefits will be derived as follows:

More accurate diagnosis.
More accurate treatments.
Less chronic disease in our midst.
A marked lowering in our death rate.
A fewer number will drift to the quack.

DISCUSSION OF DR. NORWOOD'S PAPER

Dr. Williams: Any man whose work is in the laboratory should realize that his field should be an aid and co-operation with the general practitioner, that to work with him is essential. He should also realize that when in contact with the referring physician he should efface himself as much as possible. The laboratory technician helps the doctor because he knows that he will be checked up on, so he is more careful in his diagnosis.

Dr. Anderson: I have been trying to get Dr. Norwood broke in to writing papers for quite a while. Now he comes out with a good one. I enjoyed it. It was full of stuff. It is hard to estimate the value of persistent and consistent laboratory work. I recall a case that was put on a rest treatment for T. B. when he was literally loaded with hook worms. When the hook worms were cleared out he got as fat as a pig in a potato patch. One time I examined a patient who had been to Memphis for a general examination, but a blood smear was over looked some way. He had lymphogenous leukemia and died in a few hours after the diagnosis was made. Let us heed what Dr. Norwood has said.

Diagnosis and Treatment of Perforated Gastric and Duodenal Ulcers

BY R. D. KIRK, JR. M. D.
Tupelo, Miss.

I shall not endeavor to differentiate gastric and duodenal ulcers in this discussion as they are so closely related. In my series of cases upon which this paper is presented, twenty-six in number, the duodenal ulcer has largely predominated. Neither do I intend to make any attempt to cover the entire field of pathology, the chronic perforating types, etc. I shall try to give you, to refresh your memories again, the symptomatology, clinical signs, and treatment of this dramatic condition.

I believe there is scarcely another abdominal catastrophe that calls for more prompt treatment by the attending physician and surgeon, or another in which the patient will be as insistent that something be done quickly, as in a perforated gastric or duodenal ulcer. You see them in agonizing pain in spite of repeated in-

jections of morphine. They attempt to hurry you in the examination but try to prevent you from palpating the abdomen ever so gently. The most characteristic feature of this pain is the sudden onset, like a bolt from the blue unheralded. Perhaps this is even the first as occured in one of my series.

As a general rule a history of heart burn, chronic indigestion, or occasional pains in the upper abdomen can be elicited. These people are usually in such agony that no previous events can be made to seem important to them. In fact they want to answer just as few questions as possible. After the operation and during the convalescence, if there is one, they often recall for you a very definite history of dyspepsia. Someone has said, some of these patients have had slight indigestion so long they have adopted it as part of their daily lives and cease to comment upon it. Good authorities claim all cases will give a definite history of ulcer if care is taken to bring it out. Others such as the late Dr. Deaver claim that there is a small percent which remain "silent" before perforation.

When a patient presents terrific agonizing pain of sudden onset, located in the epigastrium, with an unwielding rigidity, often in a flat abdomen, costal breathing, grunting with each respiration, anxious expression, set in an immovable frog-like posture, and in a cold sweat, the picture is that of a perforated ulcer. They are in extreme shock, provided we use the term shock to describe his appearance and not his true state of condition as regards the circulation. The pulse is usually very good when seen early. Perhaps not over ninety and of good volume. Some have perhaps made the mistake of waiting for an accelerated pulse which only comes after the inevitable peritonitis has taken a strong hold. To wait for all the cardinal signs of shock is neglect and courting disaster.

There is one observation I have made on all the cases I have seen early after the perforation, which I would like to mention for what it may be worth. Many authors and the men I have been associated with have spoken of the short costal breating in these cases but none that I have been able to find have mentioned a symptom which has invariably been present in all my early cases, those seen in a few hrs. after perforation, and that is, a very definite respiratory grunt. This grunt is much more marked than that heard in pneumonia. Perhaps this is due to pain as the diaphragm encroaches upon the inflamed peritoneum and upper abdominal contents thus forcing the acid contents of the stomach out into the abdomen, or is it a reflex phenomenon thru the phrenic, sympathetic, or what not?

Nausea and vomiting in my series has been very variable, depending upon several factors, such as the size of the perforation, advancement of peritonitis, previous intake of food etc.

In the diagnosis of this condition, it should not be the air of the attendant to try and make a refined finished diagnosis neither should he employ "watchful waiting". It is obvious that an abdominal catastrophe has occured whether it be a perforation or something just as grave. Quickness of action is the essence of good judgment in an emergency of this character, and in the presence of the clinical picture just described, neither the doctor nor surgeon can be held blameless who will delay to make a nice diagnosis before operating. As some have said, "If err we must, as sometimes we may, let us be sure to err on the safe side." When in doubt, operate.

Just a few words as to the differential diagnosis.

Perhaps the hardest differential diagnosis to make would be an acute pancreatitis. In this the pain is terrific and more localized in the epigastrium. This however, occurs usually in well nourished rather fat individuals, who will perhaps give a history of gall bladder disease. The pain is more localized in the epigastrium where a mass can usually be felt. Pulse is bad from the start corresponding to the looks of the patient which as I related before is directly opposite that of perforated ulcer. A peculiar cyanosis, first described by Halstead, appearing upon the face and abdomen, is often seen in pancreatitis.

In acute thoracic diseases with a diaphragmatic pleurisy, often the pain is severe and referred to the abdomen but here the temperature is higher and respirations faster. The ratio of temperature, pulse, and respirations are different. With the other chest signs as friction rubs if obtainable, etc. are also of help.

Other conditions in the abdomen that one must think of are volvulus, acute perforation of gall bladder mesenteric thrombosis, and acute appendicitis. These I will only mention as time will not permit of full discussion of each one.

In the treatment of these conditions as I have mentioned before, the thing of prime importance is early operation. Having decided to operate, then comes the operation itself. We must here realize that we are dealing with a patient that is usually dehydrated, with a disturbed ratio of blood chlorides. Means must be arranged to correct this if possible as soon as feasible. Opiates should not be used sparingly.

As to the technique of operation there are several procedures in practice. I prefer a high right para-median incision of ample length. This gives ample room for a gastric and duodenal exposure.

There are several methods of dealing with the condition in the abdomen, each designed to meet certain conditions; namely,

(1) Simple Suture of perforation.
(2) Suture of perforation together with posterior gastro-enterostomy.
(3) Pyloroplasty or partial gastrectomy with anastamosis.

I must confess my attitude toward conservatism and also I would like to say that I attribute part of this to my lack of experience with the more complicated gastric operations. However, in face of the results I have had in my cases to date, I think the plan I have used, simple suture of perforation, has been sufficient. I have been fortunate I suppose not to encounter any cases in which as far as I was able to determine, there was sufficient obstruction in the duodenum to warrant further operative procedure. I have had some cases that I am sure a gastroenterostomy could have been performed safely, but I have not seen that it was indicated. In fact, I have always felt that it would be safer to operate later again in those cases that called for it under more favorable conditions. Also, I have felt that the mortality rate could not help be higher when additional work was done. Often the field is sterile in spite of all the soiled appearance, but it is impossible to know just when this is the case and to do a gastroenterostomy in the presence of infection, opening up the lesser cavity, means a spreading presence of infection, opening up the lesser cavity, means a spreading peritonitis. I do not believe there is any advantage, from a drainage standpoint, of a gastroenterostomy. Neither do I fear enough the danger of leakage from a simple closure, to do a gastroenterostomy. I believe the one main indication, which I have not had or recognized, for additional procedures other than simple closure, is a stenosis at the pylorus after perforation has been closed. I believe a Finney pyloroplasty is the operation of choice in selected cases. The perforation may be closed either by purse string or mattress suture, the choice of each to be determined by amount of enduration in tissues, and reinforced by over flap of adjacent omentum. A report from the New York Hospital states that in 99 cases that had simple closure alone at the primary operation only 10 required secondary operation of gastroenterostomy. Certainly these remaining ten could be done under more favorable conditions then than at the time of perforation.

The question of drainage will always arise. It is certainly a temptation to drain from all possible sources when we see the abdomen so contaminated. I think the judgment of the operator in each particular case should decide this. The time that has elapsed since the perforation should be a deciding factor. The more cases I have, the more I am convinced that drainage of these cases is rarely indicated. Those I have drained, and they are in the majority, I have seen but little benefit except in two cases in which I got a purulent discharge for several days. If it is to be used it should be removed early. A drain placed in the supra-pubic region should be of benefit in late

cases. I believe it is folly to think we can drain the entire abdomen. Of this series 35 percent were closed without drainage.

The post-operative care should consist of nothing by mouth for several days, to be governed by the individual case, morphine every four hrs., normal saline by clisis, and often hypertonic salt solution if peritonitis is present. Glucose by infusion and clisis as indicated I have discontinued the Murphy Drip and rectal instillations as I have deemed that method of treatment as uncertain and as an annoyance to the patient, also because it excites peristalsis which should be limited if possible. In those cases with peritonitis, enemas should rarely if ever be given until the patient is well on the road to convalescence.

If the patient is fortunate to recover, he should be kept on a strict diet and medicinal alkalies until free of symptoms and then some.

Of the twenty-six patients I have had, six died, giving a mortality rate of 23 plus percent. The average time elapsing after perforation before operation was 23 hours. The shortest was 2 hours and the longest was 76 hours in a case in which the gall bladder blocked the perforation. These figures mean practically nothing and are misleading as some in this series had gone long hours before operation thus pulling the average time up. However in this series there were only three cases in which the time elapsing was under twelve hours. Some surgeons generally regard the dead line around the fifteenth hour unless some plugging up has taken place by some abdominal viscera.

Discussion of Dr. Kirk's paper "Diagnosis and Treatment of Perforated Gastric and Duodenal Ulcers."

Dr. Sutherland: This paper should be discussed by a person who is thoroughly familiar with it. There are two cases I should like to mention which were brought in suffering excruciating pain. After a few hours were pulseless and I did not operate. Both died. I suggest that Dr. Sanders and Dr. Crisler take my time; both men are more experienced than I.

Dr. Sanders: I want to say that Dr. Kirk's experience has been unique and certainly worthy of comment. I met a friend this morning who had just returned from England, where perforated ulcers seem far more prevalent than in this country. Why? All the men report their cases: If we in America would report our cases there would be just as many as in England —What shall we do with ulcers? I think one thing is to handle the cases surgically rather than medically. Many ulcers go on for a long time without perforating, and I don't mean that ulcers ought not to be treated medically. Nor is surgical treatment perfect, but there are not so many catastrophes as there are in the

medically managed ulcers. I was looking up my cases before coming down and found that in the last five years I have had 76 cases, 33 of whom were men, with an average age of 34 years. Usually the patient will lie perfectly still—this is contra-distinctice to the kidney stone and gall colic patient—and he wants to remain still. The muscles are board-like, rigid; nature's protection. The perforated ulcer problem is a dramatic catastrophe that demands immediate action. And the main points are; to sand-bag the hole, stop the leak and save a life.

Dr. Byran: Is death inevitable when the ulcer perforates and no surgery is employed?

Dr. Sanders: When there is an immediate pouring out of the gastric contents and there is no protection, there is no hope. But when nature has thrown a little omentum protection around the perforation, there might be a chance for recovery.

Dr. Crisler: I was very much impressed by Dr. Kirk's paper, particularly the part about taking the patient's history. One always finds that one cannot get the patient interested in his history. We have to take only the present history and make the diagnosis from a careful examination in the field of the abdomen. However, I don't feel quite as Dr. Sanders and others about surgery.

Among the doctors over the country a pretty high percent of them have ulcer, and they usually carry a little soda-mint tablet along in their pockets to take, so they must prefer that the patient be given medical treatment in most cases, except acute ulcers. I think that after we have operated upon a patient we should turn him back to the medical man for treatment and diet, for he is by no means well.

Dr. Kirk: I thank these doctors who have offered these fine suggestions. I would suggest to Dr. Sutherland that his two cases were probably mesenteric thrombosis. That is my guess, for the pulse and patient went bad too quickly. I might add that if the whole responsibility were placed upon the medical man, then we should have fewer perforations.

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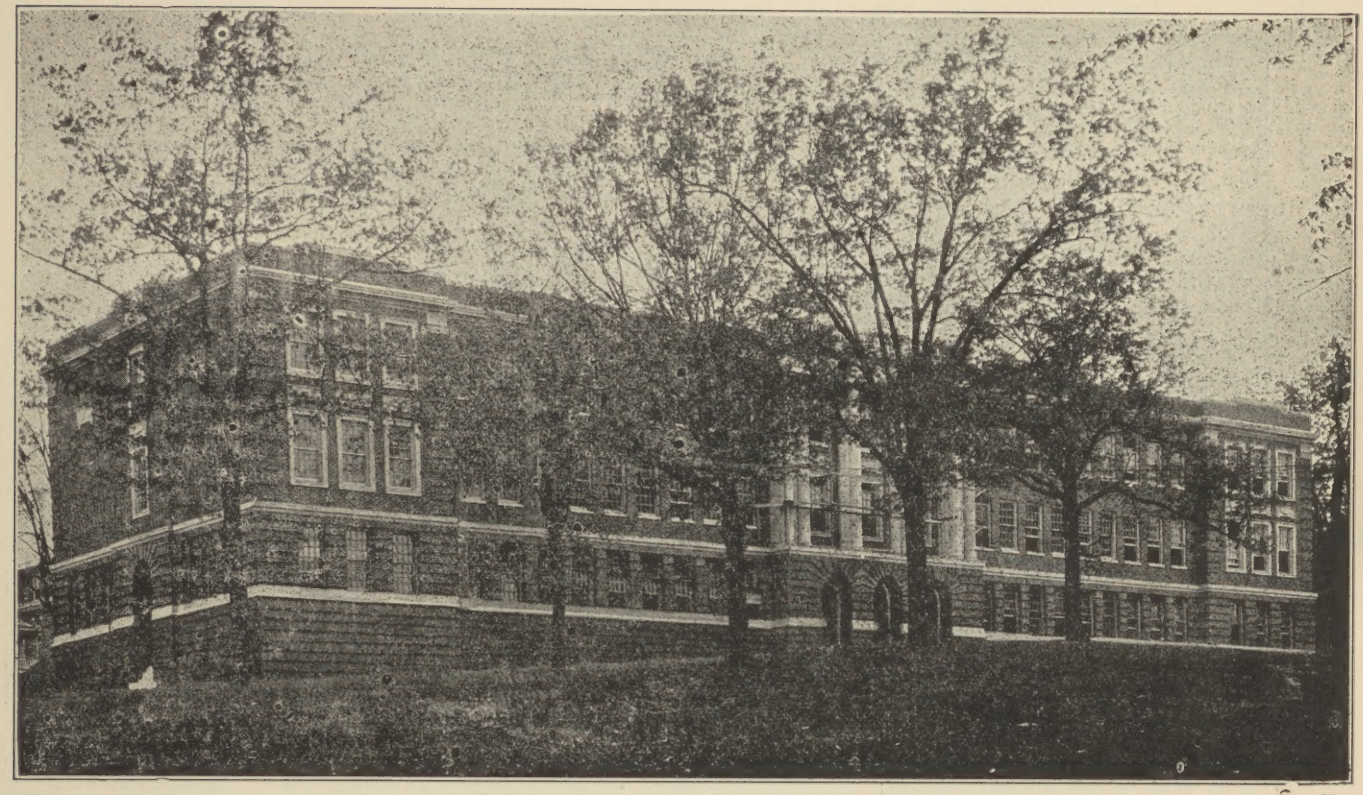

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